COPY

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 7007 0710 0002 7979 0895

December 15, 2010

Thair Pond, Administrator
Tomorrow's Hope - Meridian
1655 Fairview Avenue, Suite 100
Boise, ID 83702

RE: Tomorrow's Hope - Meridian, Provider #13G033

Dear Mr. Pond:

Based on the Medicaid/Licensure survey completed at Tomorrow's Hope - Meridian on December 2, 2010, we have determined that Tomorrow's Hope - Meridian is out of compliance with the Medicaid Intermediate Care Facility for Persons with Mental Retardation (ICF/MR) Conditions of Participation on **Client Protections (42 CFR 483.420) and Client Behavior and Facility Practices (42 CFR 483.450)**. To participate as a provider of services in the Medicaid program, an ICF/MR must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

The deficiencies which caused these Conditions to be unmet, substantially limit the capacity of Tomorrow's Hope - Meridian to furnish services of an adequate level or quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567). A similar form indicates State Licensure deficiencies.

You have an opportunity to make corrections of those deficiencies, which led to the finding of non-compliance with the Conditions of Participation referenced above by submitting a written Credible Allegation of Compliance/Plan of Correction.

It is important that your Credible Allegation/Plan of Correction address each deficiency in the following manner:

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;

2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;

4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,

5. Include dates when corrective action will be completed.

Sign and date the form(s) in the space provided at the bottom of the first page.

Such corrections must be achieved and compliance verified by this office, before January 16, 2011. To allow time for a revisit to verify corrections prior to that date, it is important that the completion dates on your Credible Allegation/Plan of Correction show compliance no later than January 8, 2011.

Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **December 28, 2010**.

Failure to correct the deficiencies and achieve compliance will result in our recommending that the Medicaid Agency terminate your approval to participate in the Medicaid Program. If you fail to notify us, we will assume you have not corrected.

Also, pursuant to the provisions of IDAPA 16.03.11.320.04, Tomorrow's Hope - Meridian ICF/MR is being issued a Provisional Intermediate Care Facility for Persons with Mental Retardation license. The license is enclosed and is effective December 2, 2010, through April 1, 2011. The conditions of the Provisional License are as follows:

1. Post the provisional license.

2. Correct all cited deficiencies and maintain compliance.

Please be aware that failure to comply with the conditions of the provisional license may result in further action being taken against the facility's license pursuant to IDAPA 16.03.11.350.

Be advised, that, consistent with IDAPA 16.05.03.300, you are entitled to request an administrative review regarding the issuance of the provisional license. To be entitled to an administrative review, you must submit a written request by **January 12, 2011**. The request must state the grounds for the facility's contention of the issuance of the provisional license. You should include any documentation or additional evidence you wish to have reviewed as part of the administrative review.

Your written request for administrative review should be addressed to:

Randy May, Deputy Administrator
Division of Medicaid -- DHW
PO Box 83720
Boise, ID 83720-0036
Phone: (208)364-1804
Fax: (208)364-1811

If you fail to submit a timely request for administrative review, the Department of Health and Welfare's decision to issue the provisional license becomes final. Please note that issues, which are not raised at an administrative review, may not be later raised at higher level hearings (IDAPA 16.05.03.301).

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in the State Informal Dispute Resolution (IDR) Process which can be found on the Internet at:

www.icfmr.dhw.idaho.gov

Scroll down until the Program Information heading on the right side is visible and there are three IDR selections to choose from.

This request must be received by December 28, 2010. If a request for informal dispute resolution is received after December 28, 2010 the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

We urge you to begin correction immediately. If you have any questions regarding this letter or the enclosed reports, please contact me at (208)334-6626.

Sincerely,

MICHAEL CASE
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MC/srm
Enclosures

TOMORROW'S HOPE, INC.
1655 FAIRVIEW AVENUE. SUITE 100
BOISE, ID 83702

PHONE: (208) 319-0760
FAX: (208) 319-0765

Michael Case
Health Care Surveyor
Non-Long Term Care
Bureau of Facility Standards
FAX: 208-364-1888

December 28, 2010

RE: Resubmit for Plan of Corrections

Dear Mr. Case,

Please find attached our corrected plan of care as per our phone call. I believe all Conditions of Participation are currently correct.

We are available for your return survey.

Sincerely,

Thair Pond
Administrator

Incl.
CC file, meridian

TOMORROW'S HOPE, INC.
1655 FAIRVIEW AVENUE. SUITE 100
BOISE, ID 83702

PHONE: (208) 319-0760
FAX: (208) 319-0765

December 22, 2010

RECEIVED
DEC 2 2 2010
FACILITY STANDARDS

Michael Case
Health Facility Surveyor
Non- Long Term Care
Bureau of Facility Standards
PO Box 83720
Boise, Idaho 83720-0009

RE: Credible Allegations of Compliance/Plan of /Corrections

Dear Mr. Case,

Please find attached our credible allegation of Compliance/Plan of Corrections for the deficiencies found during your recent survey of our Meridian Intermediate Care Facility. We believe all Conditions of Participation are in place and deficiencies found have been corrected as of this date.

We are readily anticipating your return to inspect for compliance.

If you have any questions, please contact me at the above numbers.
Sincerely,

Thair Pond
Administrator

Incl.
Cc. File, Meridian

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G033	A. BUILDING _____ B. WING _____	12/02/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOMORROW'S HOPE - MERIDIAN	1821 GREENHEAD MERIDIAN, ID 83642

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following deficiencies were cited during the annual recertification survey. The survey was conducted by: Michael Case, LSW, QMRP, Team Lead Common abbreviations/symbols used in this report are: ABC - Antecedent/Behavior/Consequence Form BIP - Behavior Intervention Plan I/A - Incident/Accident IDT - Interdisciplinary Team IPP - Individual Program Plan OCD - Obsessive Compulsive Disorder PQ - Para-Qualified Mental Retardation Professional QMRP - Qualified Mental Retardation Professional SIB - Self Injurious Behavior SLA - Seizure Like Activity	W 000	RECEIVED DEC 2 2 2010 FACILITY STANDARDS	
W 122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Based on observation, review of the facility's policies and procedures, incident/accident reports, record review, and staff interviews it was determined the facility failed to provide the necessary client protections and ensure steps were taken to protect an individual from self abuse. These failures resulted in a lack of effective systems to prevent an individual from being subjected to self abuse resulting in ongoing	W 122	W122 Refer to W149	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Thair Pond, Administrator 12/222/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 122	Continued From page 1 head injuries and constituted serious and immediate jeopardy to the health and safety of an individual. The findings include: 1. Refer to W149 as it relates to the facility's failure to adequately implement policies necessary to protect individuals from abuse, neglect, and/or mistreatment.	W 122		
W 127	483.420(a)(5) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interviews it was determined the facility failed to ensure an individual was not subjected to ongoing self abuse for 1 of 2 individuals (Individual #1) reviewed, who engaged in self injurious behavior. This resulted in an individual sustaining ongoing head injuries from hitting his head which placed him in immediate jeopardy. The findings include: 1. Individual #1's 6/16/10 IPP stated he was a 31 year old male whose diagnoses included profound mental retardation, Lennox-Gastaut Syndrome (a seizure disorder), and autism. During the entrance conference on 11/29/10 at 9:10 a.m., the Administrator informed the survey team that Individual #1 had experienced an increase in head banging behavior. Individual #1's BIP, dated 3/25/10, stated he engaged in SIB, defined as slapping his face with	W 127	W127 Client #1's program has been updated to put his helmet on sooner and to clarify when to put the helmet on, where the helmet is to kept, and what to do if he is resistent to wearing the helmet. PQ responsible by 11/29/10 Training was don with all staff regarding the change in the behavior plan to ensure all staff know when to put the helmet on PQ responsible by 11/30/10 Behavior plans will be reviewed at least quarterly during monthly QA to ensure the program effectiveness vs the behavior numbers and changes made as needed Program Director responsible by 12/15/10	

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W 127	Continued From page 2 his hand or hitting his head on a wall, window, table, or any other object that was near. The BIP stated Individual #1 "has a scar on his forehead from hitting his head on objects. He has also had to go to the emergency room for stitches several times." Individual #1's BIP stated if he appeared he was going to hit himself, staff were to prompt him to touch a black card indicating he wanted to take a break, move away, and monitor in case they needed to block. However, the plan did not indicate how or when to block hits. Additionally, the BIP stated if Individual #1 hit his head, staff were to move away and monitor. If he had a third episode of hitting his head and the task was something that needed to be done, staff were to place a helmet on Individual #1's head. The BIP did not include the location of the helmet. As written the BIP did not include staff intervention when Individual #1 hit his head other than to monitor until after the third episode of SIB. The BIP stated an episode began when Individual #1 engaged in SIB and ended when Individual #1 had not had any SIB for 5 minutes. During an interview on 11/29/10 from 2:26 - 2:35 p.m., the PQ stated an episode started when Individual #1 started to hit himself, and stopped when he stopped hitting himself. The PQ stated an episode could include multiple hits. The PQ stated Individual #1's helmet was not applied until after the third episode. Three direct care staff were interviewed on 11/29/10 from 2:05 - 2:20 p.m. All three direct care staff stated Individual #1's helmet was not applied until after 3 episodes of SIB which could include multiple hits to the head with his hand or	W 127		

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W 127	Continued From page 3 an object, or head hits to hard objects. Additionally, all three staff indicated different locations for where Individual #1's helmet was kept. Individual #1's BIP stated episodes of SIB were to be recorded on an ABC form. Individual #1's behavioral summary data from 6/1/10 to 10/31/10 stated he had engaged in hitting his head at the following rates: - 6/10: Individual #1 had 138 head hits in 54 episodes, and had the helmet applied 7 times. - 7/10: Individual #1 had 253 head hits in 91 episodes, and had the helmet applied 16 times. - 8/10: Individual #1 had 571 head hits in 168 episodes, and had the helmet applied 69 times. - 9/10: Individual #1 had 1243 head hits in 178 episodes, and had the helmet applied 23 times. - 10/10: Individual #1 had 1351 head hits in 156 episodes, and had the helmet applied 12 times. Individual #1's BIP did not include sufficient intervention for SIB to ensure his safety from potential head injury. On 11/29/10 at 2:20 p.m., Individual #1 was observed to have a raised area, approximately 2 inches in diameter, in the center of his forehead. The raised area was bluish-purple in color and had a 1 inch scabbed over laceration in the center. Additionally, Individual #1's Incident/Accident Reports and ABC Forms, dated 6/1/10 - 11/29/10,	W 127		

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W 127	Continued From page 4 documented he continued to sustain injuries which included, but were not limited to, the following: 6/10: - Individual #1's record contained a Neurological Assessment Flowsheet attached to an I/A documenting potential head injury due to SLA. No additional documentation regarding neurological checks could be found. Further, review of Individual #1's ABC forms documented head hits to hard objects no less than 41 times in 6/10. However, the documentation indicated his helmet was used for head hits to hard objects only 3 times. Additional, neurological checks for documented head hits to hard objects were not completed. 7/10: - An Incident/Accident Report, dated 7/27/10 at 11:15 a.m., stated Individual #1 "hit head on wall 1 time and craked [sic] wall size of a baseball." A Neurological Assessment Flowsheet was attached to the I/A. No additional documentation regarding neurological checks could be found. Further, review of Individual #1's ABC forms documented head hits to hard objects no less than 57 times in 7/10. However, the documentation indicated his helmet was used for head hits to hard objects only 6 times. Additionally, other than the neurological check attached to the 7/27/10 I/A form, neurological checks for documented head hits to hard objects were not completed. 8/10: - An Incident/Accident Report, dated 8/1/10 at	W 127		

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W 127	Continued From page 5 8:40 a.m., stated Individual #1 "hit his head on the counter, cutting his forehead approximately 1/4" (inch) long." - An Incident/Accident Report, dated 8/4/10 at 1:30 p.m., stated Individual #1 "hit his head on the wall and put a small crack in the wall." - An Incident/Accident Report, dated 8/11/10 at 7:08 p.m., stated Individual #1 "walked by wall (and) HH (hit head) wall X1 (one time)." A Neurological Assessment Flowsheet was attached to each I/A form. Individual #1's record contained an additional Neurological Assessment Flowsheet, started 8/6/10, that was not attached to an I/A form, but documented a potential head injury due to SLA. No additional documentation regarding neurological checks could be found. Further, review of Individual #1's ABC forms documented head hits to hard objects no less than 62 times in 8/10. However, the documentation indicated his helmet was used for head hits to hard objects only 18 times. Additionally, other than the neurological checks attached to the 8/1/10, 8/4/10, and 8/11/10 I/A forms, and the neurological check started 8/6/10, neurological checks for documented head hits to hard objects were not completed. 9/10: - An Incident/Accident Report, dated 9/8/10 at 4:00 p.m., stated Individual #1 "hit wall with hand, 1 HH with hand coming out of med room, went to dump trash can over [staff name] caught trash can hit head 1X with hand then 1 head hit on wall [staff name] blocked. [Individual #1] walked over	W 127		

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W 127	Continued From page 6 to couch hit head 1 with hand and 4 times on wall puting [sic] a hole in the wall." - An Incident/Accident Report, dated 9/16/10 at 6:30 p.m., stated Individual #1 "made a hole in the wall with his head...hit head on wall 4X causing the wall to break." - An Incident/Accident Report, dated 9/21/10 at 11:40 a.m., stated Individual #1 "HH (hit head) wall in kitchen denting wall." A Neurological Assessment Flowsheet was attached to each I/A form. No additional documentation regarding neurological checks could be found. Further, review of Individual #1's ABC forms documented head hits to hard objects no less than 174 times in 9/10. However, the documentation indicated his helmet was used for head hits to hard objects only 4 times. Additionally, other than the neurological checks attached to the 9/8/10, 9/16/10, and 9/21/10 I/A forms, neurological checks for documented head hits to hard objects were not completed. 10/10: - An Incident/Accident Report, dated 10/5/10 at 7:55 p.m., stated Individual #1 "hit his head on the counter 4X before staff were able to block. Broke open scab on forehead causing it to bleed." A Neurological Assessment Flowsheet was attached to the I/A form. No additional documentation regarding neurological checks could be found. Further, review of Individual #1's ABC forms documented head hits to hard objects no less than 98 times in	W 127		

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W 127	Continued From page 7 10/10. However, the documentation indicated his helmet was used for head hits to hard objects only 3 times. Additionally, other than the neurological check attached to the 10/5/10 I/A form, neurological checks for documented head hits to hard objects were not completed. 11/10: - An Incident/Accident Report, dated 11/3/10 at 11:30 a.m., stated Individual #1 "hit head on wall, cracking wall above towel bar." - An Incident/Accident Report, dated 11/8/10 at 11:20 a.m., stated Individual #1 "hit head on wall 2X and broke wall." A Neurological Assessment Flowsheet was attached to each I/A form. No additional documentation regarding neurological checks could be found. Further, review of Individual #1's ABC forms from 11/1/10 - 11/29/10 documented head hits to hard objects no less than 67 times. However, the documentation indicated his helmet was used for head hits to hard objects only 5 times. Additionally, other than the neurological checks attached to the 11/3/10 and 11/8/10 I/A forms, neurological checks for documented head hits to hard objects were not completed. The facility failed to ensure Individual #1 received sufficient monitoring for potential head injury related to SIB. The Right To Protection From Abuse section of the facility's Policy and Procedures, revised 1/10, defined neglect as "the failure to provide goods or services necessary to avoid physical or	W 127		

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W 127	Continued From page 8 psychological harm." Individual #1 required the use of a helmet to keep him safe from injury during SIB. However, the BIP did not require the implementation of the helmet until the third episode of SIB, where each episode could include multiple hits to the head or head hits to hard objects. Additionally, the BIP did not include the location of the helmet and staff were not clear as to where the helmet was to be kept. Further, Individual #1 engaged in repeated head hits to hard objects with no neurological checks to monitor for injury. The cumulative effect of these deficient practices placed Individual #1 in immediate jeopardy due to the potential for him to sustain serious harm, impairment or death, caused by self injury. The facility failed to provide sufficient interventions necessary to keep Individual #1 safe when he engaged in SIB. Note: On 11/29/10 at 5:55 p.m., the facility submitted an immediate Plan of Correction, dated 11/29/10, which showed Individual #1's BIP had been revised to ensure immediate helmet use for head hits to hard objects and blocking for hitting his head with his hand. The location of the helmet was also clarified to ensure it was kept with Individual #1. All staff currently working had been trained on the new program, and the facility had implemented a plan to ensure no staff worked with Individual #1 until they were trained on the new program. Based on observations and staff interviews conducted the evening of 11/29/10 and the morning of 11/30/10, it was determined the immediate jeopardy was abated.	W 127		
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS	W 149		

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W 149	Continued From page 9 The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on review of the facility's policies and procedures, review of investigations, and staff interview, it was determined the facility failed to adequately implement policies necessary to protect individuals from abuse, neglect and/or mistreatment. That failure directly impacted 3 of 8 individuals (Individuals #1 - #3), and had the potential to impact 7 or 7 individuals (Individuals #1 - #7) residing at the facility. This resulted in the potential for individuals to be unprotected from abuse, neglect and/or mistreatment, and resulted in one individual being placed in immediate jeopardy. The findings include: 1. Refer to W127 as it relates to the facility's failure to ensure policies related to neglect were sufficiently implemented to prevent Individual #1 from sustaining potential head injury caused by ongoing self injurious behavior. 2. Refer to W153 as it relates to the facility's failure to ensure all allegations of abuse were immediately reported to the administrator.	W 149	W149 Refer to tags W127 and W153	
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.	W 153		

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W 153	Continued From page 10 This STANDARD is not met as evidenced by: Based on review of investigations and staff interview, it was determined the facility failed to ensure all allegations of abuse were immediately reported to the administrator for 1 of 1 investigation conducted by the facility. This resulted in the potential for on-going abuse to occur. Findings include: 1. The facility's Policies and Procedures, revised 1/10, included directions for staff when violations of resident rights or abuse was witnessed which included the following: - Ensure the safety of resident. - Observing staff were to remove the offending staff from the situation and immediately inform the PQ or QMRP. - The Administrator/Representative was to be notified through the Administrative Beeper immediately. An Incident/Accident Report form, dated 4/2/10, alleged a staff was physically and verbally abusive towards Individual #2 and Individual #3 between 5:30 and 9:00 p.m. The attached investigation documented the facility's Policy and Procedures were not implemented as follows: - Staff A witnessed Staff C yelling at both Individual #2 and Individual #3 at various times throughout the shift. Additionally, Staff A witnessed Staff C push Individual #3 into a chair. - Staff B witnessed Staff C yelling at both Individual #2 and Individual #3 at various times throughout the shift. Additionally, Staff B	W 153	W153 All staff have been retrained on the abuse policy to ensure they know when to notify the Administrator of possible abuse allegations and to ensure they know what immediately is and how to ensure the client is safe PQ responsible by 12/15/10 All abuse allegations to include what was done to ensure the safety of the clients and what corrective actions to be taken QMRP responsible by 12/15/10 Abuse policy to be trained quarterly with all staff. Training to be reviewed during monthly QA PQ responsible by 12/15/10	

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W 153	Continued From page 11 witnessed Staff C pulling Individual #3 by the legs in order to position him on a bed. The investigation documented Staff A and Staff B waited until 4/3/10 to report the incident to the p.m. Shift Lead. The Shift Lead then contacted the Administrator/Representative. The documentation did not indicate either Staff A or Staff B had ensured the safety of Individuals #2 and #3, had removed Staff C from the situation and immediately informed the PQ or QMRP, or immediately informed the Administrator/Representative. During an interview on 12/2/10 from 9:35 - 11:15 a.m., the PQ stated the staff who witnessed the alleged abuse should have immediately protected the individuals and reported the incidents. The PQ stated the facility's policy was not implemented as written and the Administrator was not immediately notified of the allegations. The facility failed to ensure all allegations of abuse were immediately reported to the Administrator.	W 153		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observations, review of the facility's policies and procedures, accident/incident reports, record review, and staff interviews it was determined the facility failed to ensure the QMRP	W 159	W159 Refer to Tags W149,214, 237, 239, 252,, 285, 290	

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W 159	Continued From page 12 provided sufficient monitoring and coordination which directly impacted 4 of 4 individuals (Individuals #1 - #4) reviewed, and had the potential to impact 7 of 7 individuals (Individuals #1 - #7) residing in the facility. That failure resulted in individuals not receiving the necessary assessments, training, and monitoring required to meet their behavioral and safety needs. The findings include: 1. Refer to W149 as it relates to the facility's failure to ensure the QMRP ensured policies to protect individuals from abuse, neglect, and/or mistreatment were adequately implemented. 2. Refer to W214 as it relates to the facility's failure to ensure the QMRP ensured behavioral assessments were current, comprehensive, and accurately identified individuals' behavioral needs. 3. Refer to W237 as it relates to the facility's failure to ensure the QMRP ensured the type of data collected was sufficient to determine the efficacy of individuals' behavior intervention strategies. 4. Refer to W239 as it relates to the facility's failure to ensure the QMRP ensured the replacement plans for individuals' maladaptive behavior was developed to meet their behavioral needs. 5. Refer to W252 as it relates to the facility's failure to ensure the QMRP ensured data was collected necessary to determine the efficacy of individuals' intervention strategies. 6. Refer to W285 as it relates to the facility's failure to ensure the QMRP ensured that	W 159		

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W 159	Continued From page 13 techniques to manage inappropriate behavior were employed with sufficient safeguards and supervision to ensure an individual's safety, welfare and civil and human rights were protected. 7. Refer to W290 as it relates to the facility's failure to ensure the QMRP ensured standing or as needed programs to control inappropriate behavior, in the absence of evidence to justify such usage, were not used.	W 159		
W 214	483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interviews it was determined the facility failed to ensure behavioral assessments were completed for 3 of 3 individuals (Individuals #1 - #3) whose behavior programs and assessments were reviewed. This resulted in a lack of information on which to base program intervention decisions. The findings include: 1. Individual #1's 6/16/10 IPP stated he was a 31 year old male whose diagnoses included profound mental retardation, Lennox-Gastaut Syndrome (a seizure disorder), and autism. His BIP, dated 3/25/10, stated he engaged in SIB, defined as slapping his face with his hand or hitting his head on a wall, window, table, or other object. The BIP stated the function of the behavior was "Escape Motivated." Individual #1's record contained a typed note,	W 214	W214 Behavior assessments have been updated for individuals number 1-3. All other residents' behavior assessments have been reviewed and changed if needed. QMRP/PQ responsible by 12/28/10 The behavior assessment tool has been updated to look at a variety of reasons behaviors could be occurring and to indentify all behavior needs and why we believe they are occurring. Program Director responsible by 12/28/10 Behavior assesments to be reviewed at least annually and as needed for all residents. Program Director responsible by 12/28/10	

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W 214	Continued From page 14 dated 5/7/99 and unsigned. The note documented it was from a "Behavior Consultation." The note summary stated "observe [Individual #1's] behavior carefully to determine when he needs higher or lower stimuli and to know when he is escape motivated. He may need help finding another activity or may communicating [sic] what he needs. Modified helmet program is OK for his protection. Continue to use it as little as possible while teaching him a tool for getting the helmet off (when calm, "touch here if you want the helmet off", and earn a token for a stimulating toy or activity). Don't give a lot of attention to head-banging." The behavior consultation did not contain information related to analyses of the potential causes, beyond that of escape motivation, such as the psychological, physiological, environmental, or social conditions which were eliciting and/or sustaining his identified maladaptive behavior. During an interview on 12/2/10 from 9:35 - 11:15 a.m., the PQ stated there was no additional assessment for Individual #1's maladaptive behavior. The facility failed to ensure Individual #1's behavioral assessment contained comprehensive information. 2. Individual #2's 3/26/10 IPP stated she was a 29 year old female whose diagnoses included moderate mental retardation and OCD. Individual #2's BIP, dated 3/26/10, stated she engaged in SIB (defined as hitting her head with her hand or fist, hitting her head on hard	W 214		

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W 214	Continued From page 15 surfaces, or biting her hand), property destruction (defined as hitting a wall causing a hole or throwing an object and breaking it), and outbursts (defined as screaming, yelling, running in her room, slamming doors, hitting furniture or walls, throwing objects around or crying). A second BIP, dated 3/26/10, stated she engaged obsessing, defined as talking repeatedly about any given situation or thing including family, going somewhere, and minor injuries. Individual #2's record included a Functional Analysis Summary, dated 8/17/04. The Analysis included a section which stated "Condition, Details, target behavior data, fringe data" and included the following information: - The section titled "Attention" stated "Saturating verbalization. Constant talking. Ran condition less than 1 min (minute) due to saturation." - The section titled "Escape" stated "1 target. Worked frantically w/a smile." - The section titled "Avoid" was blank. - The section titled "Ignore" stated "Trolled. Immediately began grunting, rubbing face, escalation, volume increased." A second page attached to the Analysis included grids labeled "Attention", "Escape," and "Ignore." Circles or X's were placed in the boxes of the grid. There was not an explanation as to what the circles and X's meant. The Analysis document stated she engaged in maladaptive behaviors for attention and included intervention recommendations.	W 214		

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W 214	Continued From page 16 The Analysis did not include information related to any of the specific maladaptive behaviors identified in her 3/26/10 behavior plans (SIB, property destruction, outbursts, or obsessing) or information related to analyses of the potential causes, beyond that of attention, such as the psychological, physiological, environmental, or social conditions which were eliciting and/or sustaining her identified maladaptive behaviors. During an interview on 12/2/10 from 9:35 - 11:15 a.m., the PQ stated there was not an assessment for all of Individual #2's maladaptive behaviors. The facility failed to ensure Individual #2's behavioral assessment contained comprehensive information. 3. Individual #3's 2/10/10 IPP stated he was a 19 year old male whose diagnoses included profound mental retardation and autism. a. During an environmental review on 11/30/10 from 9:45 - 10:20 a.m., Individual #3's window was noted to have an attached alarm that emitted an audible signal when the window was opened. The PQ, who was present during the review, stated the alarm was installed after Individual #3 had eloped through the window. Individual #3's BIP, dated 7/29/10, stated he engaged in eloping, defined as pushing out his screen and going out of his window. The BIP stated the function of the behavior was "Automatic reinforcement" (undefined). A behavioral assessment containing information related to analyses of the potential causes,	W 214		

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W 214	Continued From page 17 beyond that of automatic reinforcement, such as the psychological, physiological, environmental, or social conditions which were eliciting and/or sustaining his identified maladaptive behavior of "eloping" could not be found. b. Individual #3's BIP, dated 2/10/10, stated he engaged in agitation, defined as stomping his feet, slamming doors, dropping to his knees, screaming or crying, loud vocalizations, slamming a shirt onto the floor, pushing staff out of his way, and moving his fingers in front of his face. The BIP stated the function of the behavior was "Automatic reinforcement" (undefined). A behavioral assessment containing information related to analyses of the potential causes, beyond that of automatic reinforcement, such as the psychological, physiological, environmental, or social conditions which were eliciting and/or sustaining his identified maladaptive behavior of "agitation" could not be found. c. Individual #3's record included a program for inappropriate touch, undated, which stated he would try to touch female staff on their breasts, would try to pull female staff's shirts up or down to look at their bras, and would masturbate in public areas. The program did not include a function of the maladaptive behaviors. A behavioral assessment containing information related to analyses of the potential causes, such as the psychological, physiological, environmental, or social conditions which were eliciting and/or sustaining his identified maladaptive behavior of "inappropriate touch" could not be found.	W 214		

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W 214	Continued From page 18 d. Individual #3's record included the following behavioral data: 7/10 - Stealing: 26 8/10 - Stealing: 19 9/10 - Steeling: 6 10/10 - Stealing: 1 However, a behavioral assessment containing information related to analyses of the potential causes, such as the psychological, physiological, environmental, or social conditions which were eliciting and/or sustaining his identified maladaptive behavior of "stealing" could not be found. During an interview on 12/2/10 from 9:35 - 11:15 a.m., the PQ stated there was not an assessment for all of Individual #3's maladaptive behaviors. The facility failed to ensure Individual #3's behavioral assessment contained comprehensive information.	W 214		
W 237	483.440(c)(5)(iv) INDIVIDUAL PROGRAM PLAN Each written training program designed to implement the objectives in the individual program plan must specify the type of data and frequency of data collection necessary to be able to assess progress toward the desired objectives. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure the type of data collected was sufficient to determine the efficacy of the intervention strategies for 2 of 4 individuals (Individuals #1 and #3) reviewed. By not ensuring appropriate data collection, the facility could not make objective decisions	W 237	W237 Individual #1, #3, and all other residents' programs and data were updated to ensure sufficient information is being collected to analyze the severity of the behavior and the effectiveness of the program. PQ responsible by 12/28/10 Programs and data to be reviewed at least quarterly during monthly QA with a PSR to ensure the program specifies the data collection and staff are collectiang data in order to assess the effectiveness of the behavior plan Program Director responsible by 12/28/10	

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W 237	Continued From page 19 regarding an individual's success or lack of success. The findings include: 1. Individual #3's 2/10/10 IPP stated he was a 19 year old male whose diagnoses included profound mental retardation and autism. a. Individual #3's record included a sheet titled "Instructions for [Individual #3] Inappropriate touch," undated, which stated he would try to touch female staff on their breasts, would try to pull female staff's shirts up or down to look at their bras, and would masturbate in public areas. The instructions did not indicate the type or frequency of data collection necessary. Additionally, Individual #3's record included a tally sheet on which staff were to document incidents of inappropriate touch, which included the date, staff initials, and a row of numbers 1 - 20 under each date. The sheet was divided into "AM" and "PM" shifts. Staff were to mark the number (1 - 20) indicating the number of times Individual #3 had engaged in inappropriate touch during the shift. However, the tally sheet did not provide information related to the maladaptive behavior that would show what was happening prior to the incident, what interventions staff provided, or how Individual #3 responded to the interventions. Individual #3's inappropriate touch instructions was not developed to include the type and frequency of data collection that would provide sufficient information to allow the facility to analyze the severity of the maladaptive behavior, or the effectiveness or appropriateness of the interventions.	W 237		

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W 237	Continued From page 20 b. Individual #3's record included a program, dated 2/10/10, for a sleep routine. The "Instruction" section of the program included a list of activities and interventions staff were to provide from 6 p.m. until Individual #3 went to bed. The "Data" stated staff were to "record that the sleep routine was followed by marking a check on the night time routine data sheet." The data collection system would not allow the facility to assess which of the interventions listed in Individual #3's program were effective, which were not, if staff followed the program correctly or in the right sequence, etc. During an interview on 12/2/10 from 9:35 - 11:15 a.m., the PQ stated Individual #3's data collection systems for inappropriate touch and sleep were not sufficient. 2. Individual #1's 6/16/10 IPP stated he was a 31 year old male whose diagnoses included profound mental retardation, Lennox-Gastaut Syndrome (a seizure disorder), and autism. Individual #1's record included a program, dated 6/16/10, for a sleep routine. The "Instruction" section of the program included a list of activities and interventions staff were to provide from 6 p.m. until Individual #1 went to bed. The "Data" stated staff were to "record that the sleep routine was followed by marking a check on the night time routine data sheet." The data collection system would not allow the facility to assess which of the interventions listed	W 237		

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W 237	Continued From page 21 in Individual #1's program were effective, which were not, if staff followed the program correctly or in the right sequence, etc. During an interview on 12/2/10 from 9:35 - 11:15 a.m., the PQ stated Individual #1's data collection systems for sleep was not sufficient.	W 237		
W 239	483.440(c)(5)(vi) INDIVIDUAL PROGRAM PLAN Each written training program designed to implement the objectives in the individual program plan must specify provision for the appropriate expression of behavior and the replacement of inappropriate behavior, if applicable, with behavior that is adaptive or appropriate. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure appropriate replacement behaviors were identified and incorporated into the behavior intervention programs for 2 of 3 individuals (Individuals #2 and #3) whose behavior intervention plans were reviewed. This resulted in individuals not receiving training to replace maladaptive behaviors. The findings include: 1. Individual #2's 3/26/10 IPP stated she was a 29 year old female whose diagnoses included moderate mental retardation and OCD. Individual #2's BIP for Obsessive Behavior, dated 3/26/10, defined obsessing as talking repeatedly about any given situation or thing including family, going somewhere, and minor injuries. A replacement behavior for obsessing could not be found in individual #2's record.	W 239	W239 Individuals 2,3,and all other residents' behavior plans were updated to include an appropriate replacement behavior for the maladaptive behavior and training is done for the replacement behavior at times where they can learn the skill and they are not engaged in maladaptive behavior. QMRP/PQ responsable by 12/28/10 All behavior plans to be reviewed annually with a PSR completed to ensure the program has all needed components and there is a training program in place for the replacement behavior. PQ responsable by 12/28/10 Programs will be reviewed at least quarterly at monthly QA to ensure the client is making progress on the replacement behavior. Program Director responsable by 12/28/10	

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W 239	Continued From page 22 During an interview on 12/2/10 from 9:35 - 11:15 a.m., the PQ stated the replacement behavior for obsessing was redirection to Individual #2's schedule. However, Individual #2's behavior data from 6/10 - 11/10 documented she engaged in obsessing over her schedule. During an interview on 12/2/10 form 9:35 - 11:15 a.m., the PQ stated Individual #2 did not have a program to teach her symptom management related to her obsessing. 2. Individual #3's 2/10/10 IPP stated he was a 19 year old male whose diagnoses included profound mental retardation and autism. a. Individual #3's record included a sheet titled "Instructions for [Individual #3] Inappropriate touch," undated, which stated he would try to touch female staff on their breasts, would try to pull female staff's shirts up or down to look at their bras, and would masturbate in public areas. However, Individual #3's record did not include a replacement behavior for inappropriate touch. b. Individual #3's BIP, dated 7/29/10, stated he engaged in eloping, defined as opening his window and pushing out his screen in order to get into the garage. The BIP stated the function of the behavior was "Automatic reinforcement." However, Individual #3's record did not include a replacement behavior for elopement. During an interview on 12/2/10 from 9:35 - 11:15 a.m., the PQ stated Individual #3 did not have replacement behaviors for inappropriate touch or	W 239		

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W 239	Continued From page 23 elopement. The facility failed to ensure Individual #2 and Individual #3 had appropriate replacement behaviors for their maladaptive behaviors.	W 239		
W 252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure data was collected sufficiently to determine the efficacy of the intervention strategies for of 2 of 3 individuals (Individuals #1 and #2) whose behavior data was reviewed. That failure had the potential to impede the ability of the IDT in evaluating the effectiveness of programmatic techniques. The findings include: 1. Individual #1's 6/16/10 IPP stated he was a 31 year old male whose diagnoses included profound mental retardation, Lennox-Gastaut Syndrome (a seizure disorder), and autism. Individual #1's BIP, dated 3/25/10, documented he engaged in SIB, defined as slapping his face with his hand or hitting his head on the wall, window, table, or other object. The facility used an ABC Form to record Individual #1's maladaptive behavioral incidents. The form included a section for the date, start time, stop time, type of restraint, duration, target	W 252	W252 All staff trained on how to fill out the ABC including more information on the anticedent, the behavior, what did staff do, what the client did and was the program effective and what ever other information may be relevent to evaluate effectiveness of program PQ responsible by 12/9/10 ABC sheets wre revised to include more information regarding what happened before, during, and after behaviors and programs ran PQ responsible by 12/9/10 ABCs to be reviewed weekly by PQ to ensure staff are filling out completely and collecting needed data and information PQ responsible by 12/15/10 ABC sheets to be reviewed at least quarterly during monthly QA to ensure they are being thoroughly filled out QMRP responsible by 12/15/10	

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	13G033	A. BUILDING _____ B. WING _____	12/02/2010

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W 252	Continued From page 24 behavior, and a narrative section. Staff were to document "A" what happened before, "B" during, and "C" after the maladaptive behavior. Individual #1's ABC Forms were reviewed from 6/10 - 11/10 and documented data was not sufficiently collected as to be comprehensive. Examples included, but were not limited to, the following: - 6/2/10 at "AM" (time not specified). The narrative section stated "A) [Individual #1] was in other clients [sic] bed. B) Staff cued [Individual #1] to get out of other clients [sic] bed and hit head 2X. C) Calmed on own." The data did not indicate if the other client was present, if Individual #1 hit his head with his hand or on an object, where on his head he hit, if staff provided any direction or intervention when he hit, or how long it took him to calm. - 7/7/10 at 10:00 a.m. The narrative section stated "A) [Individual #1] outside staff stood next to him [sic]. B) [Individual #1] had 1HH. C) [Individual #1] calmed on own." The data did not indicate what staff were doing when standing next to Individual #1, what he was doing, where he hit his head, what he hit his head with, or how long it took him to calm. - 8/1/10, time not specified. The narrative section stated "A) [Individual #1] was being assited [sic] in the bathroom. B) [Individual #1] appeared upset started throwing stuff on the floor and hit head on bathroom sink and cut the top part of his head. Tryed [sic] to redirect [Individual #1] with snack, bathroom, but [Individual #1] did not redirect. [Individual #1] hit head on wall and window seil [sic]. [Individual #1] had helmet on and off all	W 252		

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W 252	Continued From page 25 shift. [Individual #1] cont. [continued] head hits." The data did not indicate how staff attempted to redirect Individual #1, when the helmet was applied and removed, what took place after removing the helmet that resulted in it's reapplication, or if Individual #1 ever calmed. - 9/29/10 at 7:00 a.m. The narrative section stated "A) During morning routine ex. [example] eating breakfast, ADL's [activities of daily living] and domestic. B) [Individual #1] would hit his head after looking at his hand. Hit head 3X during med pass. Hit hit [sic] 3X during breakfast after being offered more. C) [Individual #1] appeared to calm on own + also w/black break card." The data did not indicate potential triggers for Individual #1's SIB, what the environment was like, other people involved, cues provided, interventions attempted or at what point during the behavior, or the nature of the head hits (i.e., with an open hand, fist, or against an object). - 10/1/10 at 8:45 a.m. The narrative section stated "A) [Individual #1] was walking in kitchen. B) hit head 1X. C) calmed on own." The data did not indicate if Individual #1 was involved in a task, where staff were or what they were doing, if staff attempted intervention, or the nature of the head hit. - 11/1/10 at 8:10 a.m. The narrative section stated "A) was in bathroom. B) [Individual #1] hit head 1X for no reason. C) calmed on own." The data did not indicate what Individual #1 was doing in the bathroom (i.e., grooming programs, toileting, bathing, etc.), if staff were providing cues to task, or what Individual #1 did following the behavior.	W 252		

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W 252	Continued From page 26 - 11/4/10 at 6:00 a.m. The narrative section stated "A) [Individual #1] was all over the house. B) Program was ran as far as break but [Individual #1] was having HHs randomly appeared to be mad one min. [minute] and happy the next even when given a break [Individual #1] would continue in behavior. C) [Individual #1] has redirected since." The data did not indicate at what point during the behavior staff were intervening or how, the nature of Individual #1's head hits (i.e., with hand, fist, on object, location on head, etc.), what Individual #1 was doing between head hits, cues or tasks provided, or Individual #1's response to staff intervention. - 11/23/10, time not indicated. The narrative section stated "A) walking threw [sic] house. B) [Individual #1] hit head 8X. C) calmed on own." The data did not indicate what Individual #1 was doing or supposed to be engaged in when walking around the house, the nature of the head hits, any interventions or cues provided by staff, or Individual #1's response to attempted interventions. Individual #1's data did not provide sufficient information that would allow the facility to analyze the severity of the maladaptive behavior, or the effectiveness or appropriateness of the interventions. During an interview on 12/2/10 from 9:35 - 11:15 a.m., the PQ stated staff were not documenting sufficient information on the ABC forms. 2. Individual #2's 3/26/10 IPP stated she was a 29 year old female whose diagnoses included moderate mental retardation and OCD.	W 252		

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W 252	Continued From page 27 Individual #2's BIP, dated 3/26/10, documented she engaged in obsessive behavior, defined as talking repeatedly about any given situation or thing, including family, going somewhere, or minor injuries. The facility used an obsession tracking sheet which included spaces for staff to document the date, start and stop time, antecedent, what Individual #2 was obsessing on (Behavior), the consequence, and staff's initials. Individual #2's obsession tracking sheets were reviewed from 6/10 - 11/10 and documented data was not sufficiently collected as to be comprehensive. Examples included, but were not limited to, the following: - 6/1/10 at "PM Shift" (start and stop time not indicated). The antecedent space was blank. Under "Behavior" staff documented "PJ's (pajamas) too hot." Under "Consequence" staff documented "talk, remind, redirect, ignore." However, the data did not indicate how long the episode lasted, if there were more than one episode, or how Individual #2 responded to interventions. - 6/20/10 at 7:00 a.m. - 12:00 p.m. Under "Antecedent," staff documented "AM Routine." Under "Behavior" staff documented "Hot outside." Under "Consequence" staff documented "talk, redirect, ignore." However, the data did not indicate if the obsession continued during the entire time, if any of the redirection steps worked or, if so, for how long, or what happened to end the session. - 7/5/10 at "AM" (start and stop time not	W 252		

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W 252	Continued From page 28 indicated). Under "Antecedent" staff documented "No work." Under "Behavior" staff documented "No work." Under "Consequence" staff documented "talk, redirect, ignore." However, the data did not indicate how long the episode lasted, if there were more than one episode, or how Individual #2 responded to interventions. - 8/22/10 at "AM" (start and stop time not indicated). Under "Antecedent" staff documented "eating breakfast." Under "Behavior" staff documented "new shoes." Under "Consequence" staff documented "talk, redirect, remind." However, the data did not indicate how long the episode lasted, if there were more than one episode, or how Individual #2 responded to interventions. - 11/5/10 at "PM" (start and stop time not indicated). Under "Antecedent" staff documented "schedule." Under "Behavior" staff documented "schedule." Under "Consequence" staff documented "talked, redirect, ignore." However, the data did not indicate how long the episode lasted, if there were more than one episode, or how Individual #2 responded to interventions. Individual #2's data did not provide sufficient information that would allow the facility to analyze the severity of the maladaptive behavior, or the effectiveness or appropriateness of the interventions. During an interview on 12/2/10 from 9:35 - 11:15 a.m., the PQ stated staff were not documenting sufficient information on the form. The facility failed to ensure data collected for individuals' maladaptive behaviors provided	W 252		

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W 252	Continued From page 29 sufficient information to adequately assess the efficacy of the intervention strategies.	W 252		
W 266	483.450 CLIENT BEHAVIOR & FACILITY PRACTICES The facility must ensure that specific client behavior and facility practices requirements are met. This CONDITION is not met as evidenced by: Based on observation, incident/accident reports, record review, and staff interviews it was determined the facility failed to ensure techniques used to manage inappropriate behavior were sufficiently developed, consistently implemented, and closely monitored. This failure resulted in individuals not receiving appropriate behavioral services and interventions. The findings include: 1. Refer to W214 as it relates to the facility's failure to ensure behavioral assessments were current, comprehensive, and accurately identified individuals' behavioral needs. 2. Refer to W237 as it relates to the facility's failure to ensure data collection was sufficient to determine the efficacy of individuals' behavior intervention strategies. 3. Refer to W239 as it relates to the facility's failure to ensure the replacement plans for individuals' maladaptive behavior were developed to meet their behavioral needs. 4. Refer to W252 as it relates to the facility's failure to ensure data was collected sufficiently to determine the efficacy of individuals' intervention	W 266	W266 Refer to Tags 214, 237, 239, 252, 290	

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W 266	Continued From page 30 strategies. 5. Refer to W290 as it relates to the facility failure to ensure standing or as needed programs to control inappropriate behavior, in the absence of evidence to justify such usage, were not used.	W 266		
W 290	483.450(b)(5) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Standing or as needed programs to control inappropriate behavior are not permitted. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure standing or as needed programs to control inappropriate behavior, in the absence of evidence to justify such usage, were not used for 1 of 3 individuals (Individual #3) whose behavioral interventions were reviewed. This resulted in interventions being incorporated into an individual's plan without justification for their use. The findings include: 1. Individual #3's 2/10/10 IPP stated he was a 19 year old male whose diagnoses included profound mental retardation and autism. During an environmental review on 11/30/10 from 9:45 - 10:20 a.m., Individual #3's window was noted to have an attached alarm that emitted an audible signal when the window was opened. The PQ, who was present during the review, stated the alarm was installed after Individual #3 had eloped through the window. Individual #3's BIP for elopement, dated 7/29/10, stated "On 4/13/10 [Individual #3] pushed his	W 290	W290 Window alarm was removed from the window PQ responsible by 12/9/10 Data will be reviewed monthly for all restrictive progmams to ensure that once the criteria has been met the restrictive component is removed. Reviewed during monthly QA Program Director responsible by 12/15/10 Training done with professionals on behavior data collection, recording behavior numbers, reviewing ABC, and identifying needs Program Director responsible by 12/21/10	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/16/2010
FORM APPROVED
OMB NO. 0938-0391

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W 290	Continued From page 31 screen out of his window and was brought back by the lawn maintenance man. Since then [Individual #3] has attempted to get out of his window 7 times and has gotten out of his window 6 times." Individual #3's behavioral data was reviewed from 6/1/10 - 11/29/10. No documented instances of elopement could be found. During an interview on 12/2/10 from 9:35 - 11:15 a.m., the PQ stated Individual #3 had engaged in elopement activity during the month of 4/10, but had not done so since. The PQ stated the alarm needed to be removed. The facility failed to ensure Individual #3's interventions were justified based on the current level (severity, intensity, duration, and frequency) of elopement he displayed.	W 290		
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure neurological checks were conducted appropriately for 2 of 2 individuals (Individuals #1 and #2) who engaged in head banging behavior. This resulted in the potential for individuals' health needs to not be met. The findings include: 1. Individual #2's 3/26/10 IPP stated she was a 29 year old female whose diagnoses included moderate mental retardation and OCD.	W 322	W322 Both clients are on daily head check. #1 has been on daily checks for 3 years and #2 is on daily head checks. We have added the component of additional neurological checks as needed following new incidents of SIB head hits which may cause injury. Other residents have the same assessments completed as needed. Nurse repsonsible by 12/28/10 Staff trained quarterly on how to fill out head and neurological checks and where to put them when completed. Neurological checks will be tracked in daily progress notes of residents. Lead worker trained on making following shift aware of need for checks and data needed regarding them. Nurse repsonsible by 12/28/10 SIB numbers will monitored and assessed on a weekly basis to determine the need of daily head checks. New incidents of SIB with head hits will have head checks and neurological assessments as needed. PQ/Nurse responsible by 12/28/10	

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W 322	Continued From page 32 Individual #2's BIP, dated 3/26/10, stated she engaged in SIB, defined as hitting her head with her hand or fist, hitting her head on a hard surface, or biting her hand. A review of Individual #2's behavioral summary data, dated 4/10 - 10/10, documented she engaged in SIB at the following rates: - 4/10: Individual #2 had 24 SIB incidents. - 5/10: Individual #2 had 30 SIB incidents. - 6/10: Individual #2 had 57 SIB incidents. - 7/10: Individual #2 had 59 SIB incidents. - 8/10: Individual #2 had 95 SIB incidents. - 9/10: Individual #2 had 126 SIB incidents. - 10/10: Individual #2 had 162 SIB incidents. Individual #2's record did not include documentation that neurological checks had been completed after instances of hitting her head. During an interview on 12/2/10 from 9:35 - 11:15 a.m., the PQ stated Individual #2 would engage in "rapid" hits of her head to a wall or door when engaging in SIB. The PQ and Nurse Supervisor, who was present during the interview, both stated staff had not been completing neurological checks following SIB in the form of head hits. 2. Individual #1's 6/16/10 IPP stated he was a 31 year old male whose diagnoses included profound mental retardation, Lennox-Gastaut Syndrome (a seizure disorder), and autism. Individual #1's BIP, dated 3/25/10, stated he engaged in SIB, defined as slapping his face with his hand or hitting his head on a wall, window, table, or any other object that was near. The BIP stated Individual #1 "has a scar on his forehead	W 322		

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W 322	Continued From page 33 from hitting his head on objects. He has also had to go to the emergency room for stitches several times." Individual #1's behavioral summary data from 6/1/10 to 10/31/10 stated he had engaged in hitting his head at the following rates: - 6/10: Individual #1 had 138 head hits. - 7/10: Individual #1 had 253 head hits. - 8/10: Individual #1 had 571 head hits. - 9/10: Individual #1 had 1243 head hits. - 10/10: Individual #1 had 1351 head hits. - 11/10: Individual #1 had 582 head hits. Additionally, Individual #1's Incident/Accident Reports and ABC Forms, dated 6/1/10 - 11/29/10, documented neurological checks were completed as follows: 6/10: - Individual #1's record contained a Neurological Assessment Flowsheet attached to an I/A documenting potential head injury due to SLA. No additional documentation regarding neurological checks could be found. Further, review of Individual #1's ABC forms documented head hits to hard objects no less than 41 times in 6/10. Additional, neurological checks for documented head hits to hard objects were not completed. 7/10: - An Incident/Accident Report, dated 7/27/10 at 11:15 a.m., stated Individual #1 "hit head on wall 1 time and craked [sic] wall size of a baseball." A Neurological Assessment Flowsheet was attached to the I/A.	W 322		

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W 322	Continued From page 34 No additional documentation regarding neurological checks could be found. Further, review of Individual #1's ABC forms documented head hits to hard objects no less than 57 times in 7/10. Additionally, other than the neurological check attached to the 7/27/10 I/A form, neurological checks for documented head hits to hard objects were not completed. 8/10: - An Incident/Accident Report, dated 8/1/10 at 8:40 a.m., stated Individual #1 "hit his head on the counter, cutting his forehead approximately 1/4" (inch) long." - An Incident/Accident Report, dated 8/4/10 at 1:30 p.m., stated Individual #1 "hit his head on the wall and put a small crack in the wall." - An Incident/Accident Report, dated 8/11/10 at 7:08 p.m., stated Individual #1 "walked by wall (and) HH (hit head) wall X1 (one time)." A Neurological Assessment Flowsheet was attached to each I/A form. Individual #1's record contained an additional Neurological Assessment Flowsheet, started 8/6/10, that was not attached to an I/A form, but documented a potential head injury due to SLA. No additional documentation regarding neurological checks could be found. Further, review of Individual #1's ABC forms documented head hits to hard objects no less than 62 times in 8/10. Additionally, other than the neurological checks attached to the 8/1/10, 8/4/10, and 8/11/10 I/A forms, and the neurological check started 8/6/10, neurological checks for	W 322		

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W 322	Continued From page 35 documented head hits to hard objects were not completed. 9/10: - An Incident/Accident Report, dated 9/8/10 at 4:00 p.m., stated Individual #1 "hit wall with hand, 1 HH with hand coming out of med room, went to dump trash can over [staff name] caught trash can hit head 1X with hand then 1 head hit on wall [staff name] blocked. [Individual #1] walked over to couch hit head 1 with hand and 4 times on wall puting [sic] a hole in the wall." - An Incident/Accident Report, dated 9/16/10 at 6:30 p.m., stated Individual #1 "made a hole in the wall with his head...hit head on wall 4X causing the wall to break." - An Incident/Accident Report, dated 9/21/10 at 11:40 a.m., stated Individual #1 "HH (hit head) wall in kitchen denting wall." A Neurological Assessment Flowsheet was attached to each I/A form. No additional documentation regarding neurological checks could be found. Further, review of Individual #1's ABC forms documented head hits to hard objects no less than 174 times in 9/10. Additionally, other than the neurological checks attached to the 9/8/10, 9/16/10, and 9/21/10 I/A forms, neurological checks for documented head hits to hard objects were not completed. 10/10: - An Incident/Accident Report, dated 10/5/10 at 7:55 p.m., stated Individual #1 "hit his head on the counter 4X before staff were able to block. Broke	W 322		

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	13G033	A. BUILDING _____ B. WING _____	12/02/2010

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W 322	Continued From page 36 open scab on forehead causing it to bleed." A Neurological Assessment Flowsheet was attached to the I/A form. No additional documentation regarding neurological checks could be found. Further, review of Individual #1's ABC forms documented head hits to hard objects no less than 98 times in 10/10. Additionally, other than the neurological check attached to the 10/5/10 I/A form, neurological checks for documented head hits to hard objects were not completed. 11/10: - An Incident/Accident Report, dated 11/3/10 at 11:30 a.m., stated Individual #1 "hit head on wall, cracking wall above towel bar." - An Incident/Accident Report, dated 11/8/10 at 11:20 a.m., stated Individual #1 "hit head on wall 2X and broke wall." A Neurological Assessment Flowsheet was attached to each I/A form. No additional documentation regarding neurological checks could be found. Further, review of Individual #1's ABC forms from 11/1/10 - 11/29/10 documented head hits to hard objects no less than 67 times. However, the documentation indicated his helmet was used for head hits to hard objects only 5 times. Additionally, other than the neurological checks attached to the 11/3/10 and 11/8/10 I/A forms, neurological checks for documented head hits to hard objects were not completed. During an interview on 12/2/10 from 9:35 - 11:15 a.m., the PQ stated neurological checks were not	W 322		

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W 322	Continued From page 37 completed for Individual #1 unless he sustained a visible injury or broke a hole in the wall. The facility failed to ensure Individual #1 was assessed for possible head injury following incidents of SIB. During the exit conference on 12/2/10 from 3:05 - 3:35 p.m., the Nurse Supervisor stated Individual #1 received daily assessment for head injury. On 12/2/10, the Nurse Supervisor faxed documentation to the survey team which showed staff were to document a "+" or "-" for the following: - Eyes - Pupils equal and react to light. - Gait - Gait is normal for the individual. - Vomiting - has vomiting occurred. - Bleeding - bleeding of eyes, ears or nose. Additionally, staff were to document a "+" or "0" by the statement "Check hand grasp equal for client." The information was included on Individual #1's Medication Administration Record and to be record daily during the AM medication pass. By completing a neurological check daily at a specified time, the facility would not be able to provide adequate assessment for potential injury (i.e., a head injury sustained at 4:00 p.m. could go undetected until the daily neurological check the following morning). The facility failed to ensure Individual #1 and Individual #2 were adequately assessed for potential head injury following incidents of SIB.	W 322		
W 326	483.460(a)(3)(iii) PHYSICIAN SERVICES	W 326		

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W 326	Continued From page 38 The facility must provide or obtain annual physical examinations of each client that at a minimum includes special studies when needed. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to obtain special studies as recommended for 3 of 4 individuals (Individuals #1, #2, and #4) whose medical records were reviewed. This resulted in individuals not receiving bone density screenings as recommended or in accordance with their needs. The findings include: 1. The National Center for Biotechnology Information (www.ncbi.nlm.nih.gov) published two articles summarizing bone density studies on individuals receiving long term antiepileptic drug therapy. One article, published in 2009 article by the American Epilepsy Society stated "Antiepileptic drug (AED) therapy for epilepsy is associated with metabolic bone disease and high risk for fractures. Reduced bone mineral density (BMD) has been reported in 20 to 75 percent of patients taking AEDs in cross-sectional studies." The article stated 3 to 5 years of AED therapy was a reasonable interval before assessing BMD. The second article, published on-line 9/6/06, stated the "effect of AED may be more pronounced in the younger rather than the older age group." a. Individual #1's 6/16/10 IPP stated he was a 31 year old male whose diagnoses included profound mental retardation, Lennox-Gastaut	W 326	W326 Indiviual #2 has had a bone density scan completed Nurse responsible by 12/15/10 The nurse has requested a doctor order for individual #1 and #4 to have a bone density screening. Will schedule appintment when order has been recieved. Nurse responsible by 11/30/10 Will ensure client receive a second opinion when first doctor denies request by the IDT to have bone screening done. Nurse responsible by 11/30/10 All residents are reviewed quarterly to ensure they recieve all needed annual physical examinations and any special exams if required as needed Nurse responsible by 1/30/11	

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W 326	Continued From page 39 Syndrome (a seizure disorder), and autism. His Physician's orders, dated 12/10, stated he received Lamictal XR (an anticonvulsant drug) 100 mg daily and Depakote ER (an anticonvulsant drug) 2500 mg daily. Individual #1's record contained a recommendation from the dietician, dated 6/21/10, which stated "Do a DEXA [bone density] scan to check bone density when pt. [patient] is sedated for his upcoming surgery." The recommendation stated Individual #1 "is at risk for developing osteoporosis d/t [due to] long-term anti-convulsant use. He fractured his maxilla in 2/09 during a seizure." A physician's note, dated 10/4/10, stated the physician would not order a DEXA scan for Individual #1 as "It is not the standard of care, and there is no evidence that doing a DEXA in a 30 year old male is helpful, nor that we should use osteoporosis medications in this setting." During an interview on 12/2/10 from 9:35 - 11:15 a.m., the Nurse Supervisor stated Individual #1 had not received a DEXA scan, nor had a second opinion from Individual #1's neurologist been obtained. b. Individual #2's 3/26/10 IPP stated she was a 29 year old female whose diagnoses included moderate mental retardation and OCD. Her physician's orders, dated 11/10, stated she received oxcarbazepine (an anticonvulsant drug) 1200 mg three times daily, and clonazepam (an anticonvulsant drug) 0.75 mg daily, and 0.5 mg as needed. Individual #2's dietary note, dated 3/25/10, stated	W 326		

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W 326	Continued From page 40 a DEXA scan should be considered due to long term use of anticonvulsant drugs. However, Individual #2's record did not contain documentation a DEXA scan. During an interview on 12/2/10 from 9:35 - 11:15 a.m., the Nurse Supervisor stated Individual #2 had been on anticonvulsant drugs at least 5 years. The Nurse Supervisor stated a DEXA scan had not been completed for Individual #2. c. Individual #4's 5/28/10 IPP stated he was a 17 year old male whose diagnoses included profound mental retardation and seizure disorder. His physician's orders, dated 12/10, stated he received divalproex (an anticonvulsant drug - generic for Depakote) 750 mg daily and clonazepam (an anticonvulsant drug) 0.25 mg daily. Individual #4's dietary note, dated 5/28/10, sated he "is at risk of developing osteoporosis d/t [due to] long-term use of Depakote ER [an anticonvulsant drug]." However, Individual #4's record did not contain documentation a DEXA scan had been completed. During an interview on 12/2/10 from 9:35 - 11:15 a.m., the Nurse Supervisor stated Individual #3 had been on anticonvulsant drugs since he was a child. The Nurse Supervisor stated a DEXA scan had not been completed for Individual #4. The facility failed to ensure Individual #1, Individual #2, and Individual #4 received special studies for bone density screening in accordance with their needs.	W 326		
W 426	483.470(d)(3) CLIENT BATHROOMS	W 426		

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W 426	Continued From page 41 The facility must, in areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 degrees Fahrenheit. This STANDARD is not met as evidenced by: Based on environmental review and staff interview, it was determined the facility failed to ensure hot water temperatures were maintained at or below 110 degrees Fahrenheit for 6 of 7 individuals (Individuals #1 and #3 - #7) who were unable to regulate water temperatures independently. This resulted in an increased risk of scald injuries during hand washing and bathing. The findings include: 1. Hot water temperatures were obtained at the facility during an environmental review on 11/30/10 from 9:45 - 10:20 a.m. and were recorded as follows: Kitchen - 114.8 degrees When asked if the individuals residing in the facility could regulate water temperatures, the PQ, who was present, stated Individual #2 was the only individual able to self regulate water temperatures. The PQ stated other individuals would turn on water by themselves. At that time, the PQ was notified of the water temperatures being too high. The water temperatures were rechecked on 11/30/10 at 3:45 p.m. and found to be at 112.8 degrees. The PQ, who was present, was notified the water temperatures were still above an acceptable limit.	W 426	W426 Maintenance person fixed the problem immediately when notified Maintenance man by 11/30/10 Weekly water checks will be taken and recorded to ensure water is not to hot or too cold PQ responsible by 12/15/10 All water temps are reviewed at monthly QA Program Director responsible by 12/15/10	

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W 426	Continued From page 42 The facility failed to ensure water temperatures were maintained at or below 110 degrees Fahrenheit. Note: Water temperatures were re-checked on 12/1/10 at 2:15 p.m. and found to be within the acceptable range.	W 426		

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MM177	16.03.11.075.09 Protection from Abuse and Restraint Protection from Abuse and Unwarranted Restraints. Each resident admitted to the facility must be protected from mental and physical abuse, and free from chemical and physical restraints except when authorized in writing by a physician for a specified period of time, or when necessary in an emergency to protect the resident from injury to himself or to others (See also Subsection 075.10). This Rule is not met as evidenced by: Refer to W122, W127, W149, and W153.	MM177	MM177 Refer to Tags 122, 127, 149, and 153 RECEIVED DEC 2 2 2010 FACILITY STANDARDS	
MM191	16.03.11.075.09(c) Last Resort Physical restraints must not be used to limit resident mobility for the convenience of staff, and must comply with life safety requirements. If a resident's behavior is such that it will result in injury to himself or others and any form of physical restraint is utilized, it must be in conjunction with a treatment procedure designed to modify the behavioral problems for which the patient is restrained and, as a last resort, after failure of attempted therapy. This Rule is not met as evidenced by: Refer to W290.	MM191	MM191 Refer to Tag W290	
MM212	16.03.11.075.17(a) Maximize Developmental Potential The treatment, services, and habilitation for each resident must be designed to maximize the developmental potential of the resident and must be provided in the setting that is least restrictive of the resident's personal liberties; and This Rule is not met as evidenced by:	MM212	MM212 Refer Tag W266	

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Thair Pond, Administrator 12/22/10

Bureau of Facility Standards

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MM212	Continued From page 1 Refer to W266.	MM212		
MM380	16.03.11.120.03(a) Building and Equipment The building and all equipment must be in good repair. The walls and floors must be of such character as to permit frequent cleaning. Walls and ceilings in kitchens, bathrooms, and utility rooms must have smooth enameled or equally washable surfaces. The building must be kept clean and sanitary, and every reasonable precaution must be taken to prevent the entrance of insects and rodents. This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to ensure the facility was kept in good repair for 7 of 7 individuals (Individuals #1 - #7) residing in the facility. This resulted in the environment being kept in ill-repair. The findings include: An environmental review was conducted on 11/30/10 from 9:45 - 10:20 a.m. During that time the following was noted: - There was a 6 inch by 4 inch dent in the wall above the light switch in the dinning room. - The front edge of the television shelf on the entertainment center was broken and the finish was peeling. - There was a 1.5 foot by 1.5 foot of patched wall above the towel bar in the hall bathroom that was missing paint. - The toilet in the hall bathroom was continuously running.	MM380	MM380 All noted deficiencies will be repaird, cleaner, or replaced to meet requirements. PQ and Maintenance responsible by 12/21/10	

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MM380	Continued From page 2 - There was a 1.5 foot by 2 foot section of patched wall by Individual #2's bed that was missing paint. - The middle drawer of Individual #2's bed frame was missing. The facility failed to ensure environmental repairs were maintained.	MM380		
MM725	16.03.11.270.01(b) QMRP The QMRP is responsible for supervising the implementation of each resident's individual plan of care, integrating the various aspects of the program, recording each resident's progress and initiating periodic review of each individual plan for necessary modifications or adjustments. This function may be provided by a QMRP outside the facility, by agreement. This Rule is not met as evidenced by: Refer to W159.	MM725	MM725 Refer to Tag W159	
MM730	16.03.11.270.01(d)(i) Diagnostic and Prognostic Data Based on complete and relevant diagnostic and prognostic data; and This Rule is not met as evidenced by: Refer to W214.	MM730	MM730 Refer to Tag W214	
MM731	16.03.11.270.01(d)(ii) Measurable Behavioral Terms Stated in specific measurable behavioral terms that permit the progress of the individual to be assessed; and This Rule is not met as evidenced by:	MM731	MM731 Refer to Tags W237 and W252	

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MM731	Continued From page 3 Refer to W237 and W252.	MM731		
MM735	16.03.11.270.02 Health Services The facility must provide a mechanism which assures that each resident's health problems are brought to the attention of a licensed nurse or physician and that evaluation and follow-up occurs relative to these problems. In addition, services which assure that prescribed and planned health services, medications and diets are made available to each resident as ordered must be provided as follows: This Rule is not met as evidenced by: Refer to W322 and W326.	MM735	MM735 Refer to Tags W322 and W326	
MM812	16.03.11.270.05(c)(ii)(f) Self Direction Self direction; and This Rule is not met as evidenced by: Refer to W239.	MM812	MM812 Refer to Tag W239	